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| |  | | --- | | **PERSONAL INFORMATION -** *PLEASE PRINT CLEARLY* | | | |
| |  | | --- | | TODAY'S DATE:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_    LEGAL/INSURANCE NAME (*if different*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB: M\_\_\_\_\_\_D\_\_\_\_\_\_\_Y\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *STREET CITY STATE ZIP* | | |
| BEST PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hm off cell  Can we leave messages at this number? YN  | | |
| ALT PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hm off cell  Can we leave messages at this number? YN | | |
| OCCUPATION (previous if retired) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *NAME PHONE RELATION* | | |
|  | | |
| HOW DID YOU HEAR ABOUT US?  Patient/Friend/Family  Healthcare practitioner  Internet   Other Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 740 N. Lake Avenue • Pasadena, CA 91104  *tel:* (626) 794-4668 • *fax:* (626) 345-9753  *email*: info@pasadenanaturealhealth.com  *web*: pasadenanaturalhealth.com | Paracelsus logo.jpg | 112 E. Olive Avenue, Suite E • Redlands, CA 92373  *tel:* (909) 793-4477 • *fax:* (909) 793-9350  *email:* info@redlandsnaturalhealth.com  *web:* redlandsnaturalhealth.com |
| **Daniel Brousseau, D.O. • Simon Barker, N.D. • Nadia Mistry, N.D.** | | |
| **ADULT INTAKE** | | |

|  |
| --- |
| PLEASE LIST YOUR HEALTH CONCERNS: |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| |  | | --- | | **PERSONAL MEDICAL HISTORY -** *Check all that apply, please note when they started* | |

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| --- | --- | --- |
| \_\_\_\_\_ AIDS/HIV Infection  \_\_\_\_\_ Allergies  \_\_\_\_\_ Anemia  \_\_\_\_\_ Arthritis  \_\_\_\_\_ Asthma  \_\_\_\_\_ Attempted Suicide  \_\_\_\_\_ Cancer  \_\_\_\_\_ Chickenpox  \_\_\_\_\_ Chronic Fatigue Syndrome  \_\_\_\_\_ Depression  \_\_\_\_\_ Eating Disorder  \_\_\_\_\_ Eczema  \_\_\_\_\_ Edema (Fluid Retention) | \_\_\_\_\_ Fibromyalgia  \_\_\_\_\_ Frequent Steroid Use  \_\_\_\_\_ Gallbladder Disease  \_\_\_\_\_ Glaucoma  \_\_\_\_\_ Gout  \_\_\_\_\_ Hayfever  \_\_\_\_\_ Heart Disease  \_\_\_\_\_ Hepatitis B or C  \_\_\_\_\_ High Blood Pressure  \_\_\_\_\_ Hives  \_\_\_\_\_ Kidney Infections  \_\_\_\_\_ Kidney Stones  \_\_\_\_\_ Liver Disease | \_\_\_\_\_ Lyme Disease  \_\_\_\_\_ Migrane Headaches  \_\_\_\_\_ Mononucleosis  \_\_\_\_\_ Neurological Disorder  \_\_\_\_\_ Occupational Exposure to Toxic  Substances  \_\_\_\_\_ Polio  \_\_\_\_\_ Seizure Disorder  \_\_\_\_\_ Sleep Apnea  \_\_\_\_\_ Stroke/TIA  \_\_\_\_\_ Substance Abuse/Addiction  \_\_\_\_\_ Thyroid Disease  \_\_\_\_\_ Tuberculosis or Positive TB Test |

**Next Page **

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| **PERSONAL MEDICAL HISTORY** *(cont'd)* |

Do you have a specific spiritual practice? Y N

*If so, please describe it:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is there anything the doctor should know in relation to this?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list the names of your healthcare providers:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all prescription and over the counter medications that you are currently taking:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Medication*** | ***Dose*** | ***Date Started*** | ***Prescribed By*** |
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**Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking:**

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| --- | --- | --- |
| ***Supplement*** | ***Dose*** | ***Date Started*** |
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Please list any severe or life-threatening allergies:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please Explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Habits**

Please indicate which substances, if any, pertain to you **N** = use **NOW** **P** = used in the **PAST**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Substance*** | ***N / P*** | ***How Much?*** | ***How Long?*** | ***Substance*** | ***N / P*** | ***How Much?*** | ***How Long?*** |
| Tobacco |  |  |  | Soda |  |  |  |
| Coffee |  |  |  | Alcohol |  |  |  |
| Black Tea |  |  |  | Recreational Drugs |  |  |  |

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? Yes No What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL MEDICAL HISTORY** *(cont'd)*  **Review of Systems** | *Please indicate the following:* **N** = a condition you have **NOW** **P** = a condition you have had in the **PAST** |
| Head Migraines\_\_\_\_\_ Headaches\_\_\_\_\_  Location of pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Worse: Light \_\_ Noise\_\_ Odors\_\_  Head Injury \_\_\_\_\_\_\_  Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  TMJ \_\_\_\_\_\_\_  Dizziness \_\_\_\_\_\_\_  Fainting \_\_\_\_\_\_\_  Seizures \_\_\_\_\_\_\_ Digestion Bowel Movement \_\_\_\_\_\_\_  X per day: 1-2\_\_\_ 2-3\_\_\_ 3-4\_\_\_ or  X per week: 1-2\_\_\_ 2-3\_\_\_ 3-4\_\_\_  Size: Sm Med Lg  Color: Brown Tan Rust  Texture: DryHard  Wet/Loose Pellets  Stools with Mucous Blood  Hemorrhoids \_\_\_\_\_\_\_  Bleeding PainfulItching  Fissures/Fistulas \_\_\_\_\_\_\_  Stool Incontinence \_\_\_\_\_\_\_  Bowel Disease \_\_\_\_\_\_\_  Liver/Gallbladder Disease \_\_\_\_\_\_\_  Ulcer \_\_\_\_\_\_\_  Heartburn \_\_\_\_\_\_\_  Bloating \_\_\_\_\_\_\_  Belching \_\_\_\_\_\_\_  Gas / Flatus \_\_\_\_\_\_\_  Nausea / Vomiting \_\_\_\_\_\_\_  Pains / Cramps \_\_\_\_\_\_\_  **Sleep**  Good Bad  How many hours? \_\_\_\_  W Wake Easily? Yes No  Why?\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_  Di Difficulty Falling Asleep? Yes No  W Wake Refreshed? Yes No  Grumpy? Yes No  Snore? Yes No  Talk? Yes No  Grind Teeth? Yes No  Sleepwalk? Yes No  Nightmares? Yes No  Dream a lot? Yes No  Preferred Sleeping Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  | | --- | --- | | **Sex/Reproductive** |  | | Change in Sex Drive  Sexually Transmitted Diseases | \_\_\_\_\_  \_\_\_\_\_ | | Painful Intercourse | \_\_\_\_\_ | | Ever Have an Abnormal Pap Smear? | \_\_\_\_\_ | | History of Sexual Abuse  DES Exposure | \_\_\_\_\_  \_\_\_\_\_ | | Frequent Yeast Infections | \_\_\_\_\_ | | Vaginal Discharge | \_\_\_\_\_ | | Age Period Began | \_\_\_\_\_ | | Regular Periods Yes  No  | \_\_\_\_\_ | | Flow: Heavy  Medium  Light  | \_\_\_\_\_ | | Length of Cycle \_\_\_\_ Days of Flow \_\_\_\_ |  | | Spotting | \_\_\_\_\_ | | Cramps | \_\_\_\_\_ | | PMS\_\_\_\_ Endometriosis\_\_\_ PID\_\_\_ |  | | Fibroids\_\_\_\_\_\_ Ovarian Cysts\_\_\_\_\_\_ |  | | Ever Used Birth Control Pills? | \_\_\_\_\_ | | How Long For?\_\_\_\_\_ How Long Ago?\_\_\_\_\_ | | | Present Birth Control | \_\_\_\_\_ | | Pregnancies (number) | \_\_\_\_\_ | | Childbirth (number) | \_\_\_\_\_ | | Complications | \_\_\_\_\_ | | Miscarriages (number) | \_\_\_\_\_ | | Abortions (number) | \_\_\_\_\_ | | Have You Had A Hysterectomy? | \_\_\_\_\_ | | Age at Menopause | \_\_\_\_\_ | | Vaginal Dryness | \_\_\_\_\_ | | Hot Flashes | \_\_\_\_\_ | | Mammograms (number) | \_\_\_\_\_ | | Date of Last Mammogram | \_\_\_\_\_ | | Prostate Enlargement | \_\_\_\_\_ | | Change in Force of Urine Stream | \_\_\_\_\_ | | Difficulty Starting Urine | \_\_\_\_\_ | | History of Undescended Testes | \_\_\_\_\_ | | Pain / Lump in Scrotum | \_\_\_\_\_ | | Discharge From Penis | \_\_\_\_\_ | | Difficulty with Erections | \_\_\_\_\_ | |  | | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  | | |

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| **PAST MEDICAL HISTORY** | *Please provide the following information* |

Hospitalization(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Serious Illnesses and Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date of Last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Last Blood Tests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Last Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Last DEXA (bone density test)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FAMILY MEDICAL HISTORY** | | | *Please indicate the following:* **YES** = Checkmark applies to you or one of your family members  **RELATION** = Self, or indicate family member (mother, aunt, father, etc.  **PAST** (**P**) = A condition you've had in the past  **Now** (**N**) = A condition you have now | |
| **CONDITION** | **YES** | **RELATION** | | **NOW (N)/**  **PAST (P)** |
| Alcoholism/Drug Addiction |  |  | |  |
| Alzheimer’s Disease |  |  | |  |
| Anemia |  |  | |  |
| Cancer |  |  | |  |
| - Type: |  |  | |  |
| - Type: |  |  | |  |
| - Type: |  |  | |  |
| Diabetes |  |  | |  |
| Heart Disease |  |  | |  |
| Osteoporosis |  |  | |  |
| Thyroid Disease |  |  | |  |
| Other: |  |  | |  |
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**•END•**

**Thank you.**

**Please return your completed forms to our front desk.**

**Your new Doctor will be with you shortly!**